

# Family and Medical Leave Act

## Internal Policy Memorandum

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The purpose of the Family and Medical Leave Act (FMLA) is to assist employees in balancing work life and family matters by providing leave for special health or family related needs. Employees who qualify are entitled to take up to 12 weeks of unpaid, job protected leave each year. Use of FMLA leave may be concurrent with eligible paid leave if desired by the employee.

### A. Eligibility for FMLA Leave

An employee may take FMLA leave if he or she meets both of the following criteria:

1. Employment with the State of Idaho has been in effect for **at least twelve months**. The twelve months do not have to be continuous employment. Employees who were on the payroll for any part of a week (even just one day), will be credited with a full week toward their total. This includes part-time or temporary workers; and
2. Has worked **at least 1,250 hours** during the immediately preceding twelve-month period. (source CFR 29.825.110) This 1250 hours means “actual time” spent working. It does not include paid vacation or sick time, nor periods of unpaid leave during which other benefits (i.e. a group health plan or workers comp) continued to be provided by their employer.

### B. Use of Paid Leave

An employee may elect to use whatever vacation, sick or other paid leave they are entitled to concurrent with their FMLA leave. If an employee elects to use EAL or compensatory time during their FMLA leave, such time cannot be counted against their 12 week FMLA entitlement.

### C. Manner of Calculating the Year for 12 Week Entitlement

The State of Idaho, for the purposes of calculating the “12-month period”, uses a rolling 12 month period measured backward from the date an employee uses any leave under this policy. Each time an employee takes leave, the amount of leave the employee has taken under this policy in the past 12 months will be computed and subtracted from the available 12 weeks of leave. The balance remaining is the amount the employee is entitled to take at that time.

## D. Purposes for FMLA Leave

The FMLA provides leave to employees for the following reasons:

### 1. Birth of a child.

- FMLA leave to care for or assist in the care of a newborn is available to all employees (female and male) as long as they are the parents or legal guardians of the child. (source CFR 29.825.114(a)(2)(ii))
- An expectant mother may take FMLA leave if her pregnancy makes her unable to work before the birth of the baby. Under the FMLA, pregnancy and pre-natal care involve continuing treatment by a health care provider, and therefore qualify as a serious health condition. (source CFR 29.825.114(A)(2)(ii))

### 2. Adoption of a child or placement of a child in foster care.

- FMLA leave may be taken for events incident to the adoption process such as pre-placement counseling sessions, court appearances, attorney consultations, and care for adopted child. This is not a conclusive list. (source CFR 29.825.112(a)(2))
- FMLA leave may be taken in conjunction with the placement of a child in foster care. (source CFR 29.825.112(a)(2))

**Limitations** An employee's right to take leave for birth and care of a newborn, or for placement of a child for adoption or foster care must conclude within 12 months of the birth or placement. (source CFR 29.825.201)

### 3. To care for employee's spouse, children (under 18\*) or parents who have a serious health condition. (Does not include siblings or in-laws.)

If employees request FMLA leave to care for family members, the employer may require a doctor's letter stating the need for support or care for the family member's illness, as well as its expected duration. (source CFR 29.825.305(a))

\* *The child must be under 18 unless he or she is incapable of self-care due to mental or physical disability.*

### 4. Employee's own serious health condition.

FMLA leave is available for the employee's own serious health condition. (source CFR 29.825.115)

## E. Definition of "Serious Health Condition"

A “Serious Health Condition” means an illness, injury, impairment, or physical or mental condition that involves one of the following:

### **1. Hospital Care**

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity<sup>1</sup> or subsequent treatment in connection with or consequent to such inpatient care.

### **2. Absence Plus Treatment**

A period of incapacity that also involves treatment<sup>2</sup> by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>3</sup> under the supervision of the health care provider.

### **3. Pregnancy**

Any period of incapacity due to pregnancy, or for prenatal care.

### **4. Chronic Conditions Requiring Treatments**

A chronic condition which:

- (a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

### **5. Permanent/Long-term Conditions Requiring Supervision**

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment

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<sup>1</sup> “Incapacity,” for purposes of FLMA, is defined to mean inability to perform one or more of the functions of one’s job, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

<sup>2</sup> Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

<sup>3</sup> A regimen of continuing treatment includes, for example, a source of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

## **6. Multiple Treatments (Non-Chronic Conditions)**

Any absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity if not treated, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), and kidney disease (dialysis).

## **F. FMLA procedures**

### **1. Where the employee knows in advance of the need to take FMLA leave.**

- An employee who knows in advance that they will take FMLA leave must give 30 days notice prior to taking such leave. (source CFR 29.825.302(a)) Such notice should include the anticipated start date of such leave, and the expected duration.
- In situations where advance notice is not possible, the employee shall notify the employer as soon as feasible. As soon as feasible ordinarily would mean employees giving at least verbal notice one to two days after the employee knows of their need for FMLA leave. (source CFR 29.825.302(b))
- Whenever an employee requests or needs FMLA leave, the employee shall complete and submit to his or her supervisor, the "FMLA Leave Request" form included in the Appendix to these policies. If the employee is not able to fill out this form, it may be filled out by others, including the supervisor, acting on the employee's behalf. (source CFR 29.825.302(b))

### **2. When it is impossible to provide advance notice.**

- If the employee is unable to provide notice because of unforeseen circumstances, an employee's friend or family member acting on the employee's behalf, can notify the employer of the employee's need to take FMLA leave. Such notice can be given by a phone call, fax or by email. (source CFR 29.825.303(b)) However, as soon as such notice is given, the employee's supervisor shall immediately complete the leave request form included in the Appendix to these policies.

### **3. FMLA Notice Letter.**

- When an employee requests FMLA leave, the employer will provide a preliminary eligibility response (either verbal or written) within two (2) business days. In all cases where the employee or his or her representative requests FMLA leave the supervisor, or other designated individuals shall send or

deliver to the employee within fifteen (15) days, the form letter entitled “Response to FMLA Request” included in Appendix to these Policies.

- Supervisors, Human Resource staff, or other designated individuals are encouraged to inform employees about the availability of FMLA leave whenever a situation arises that would indicate that the employee may be eligible for, and might benefit from FMLA leave. Such notice may be verbal, but is normally given by providing the “FMLA Leave Request” that is supplied in the Appendix.
- An employee may be required to provide a “Fitness for Duty” certification from their medical practitioner, if due to the nature of the health condition and the job:
  - (a) light duty work or other accommodation is requested; or
  - (b) the agency, having a reasonable basis in fact to do so, requires assurance that returning to work would not create a significant risk of substantial harm to the employee or others.

The employee must be notified of the requirement of a “Fitness for Duty” certification in the memo of understanding when the employee is notified that their request for FMLA leave is approved. (source CFR 29.825.310)

#### **4. Certification Requirement (Proof of Medical Necessity).**

- When an employee requests FMLA leave for their own medical condition or to care for family members, the employer may require the employee to furnish a doctor’s statement certifying the medical information necessary to determine the employee’s eligibility for FMLA leave at the time such leave is requested. The employee must return the completed medical documentation within 15 days from the date he or she makes the request for leave, unless a request for extension is received and approved. If an employee fails to provide medical documentation FMLA leave may be denied.
- If the requested FMLA leave was unforeseen, the employer should request certification within 2 business days after the leave commences or is designated FMLA leave. (source CFR 29.825.305(c)) The employee should then provide the certification within 15 days of the receipt of the request. (See Medical Documentation Form in appendix.)
- To determine the extent of an employee’s serious health condition, if the first medical certification appears to lack validity, the employer has the right to request a second opinion. If the second opinion is different than the first opinion, the employer can request a third medical opinion. The third opinion will be binding. If second and third opinions are necessary, they will be paid for by the employer. (source CFR 29.825.307)

## 5. Procedures for Coding FMLA leave.

- Employees should not code FMLA leave to their timesheet until the employer has verified the employee's eligibility for such leave. Such verification can be either orally or in writing. (source CFR 29.825.112)
- Sick leave taken during family leave is coded as "FMS," vacation leave taken during family leave is coded as "FMV." If the employee runs out of sick and vacation leave, the remainder of the 12 week period is coded as "FML" which is family leave without pay. (source CFR 29.825.207)
- Employees on FMLA leave who are concurrently using available sick or vacation time, will accrue sick and vacation hours at the same rate as if they were not on FMLA. However, once an employee goes on FMLA without pay (coded "FML"), they no longer accrue leave credits. (source CFR 29.825.207)

## G. Employee's FMLA Rights

While on FMLA leave, the employee's health and dental benefits will remain unchanged. Thus, the employee will still be responsible for his or her share of the monthly health and dental premiums. As long as the employee is using sick or vacation leave balances to receive a full paycheck while on FMLA leave, the employee's portion of health and dental insurance premiums will be deducted from the paychecks as usual. However, if the employee is not receiving a sufficient paycheck, he or she must arrange to pay the employee's portion of health and dental insurance premiums. If the employee does not return to work after FMLA leave for reasons beyond his or her medical condition, the employer can require the employee to reimburse the State's share of the premiums paid during his or her absence. (source CFR 28.825.210, 29.825.213)

- An employee's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to **before** using FMLA leave.
- Use of FMLA leave cannot be counted against the employee for any disciplinary action regarding attendance.
- Upon return from FMLA leave employees are entitled to be restored to the position they held prior to their FMLA leave, or to be restored to a substantially equivalent position with substantially equivalent benefits, pay, or other terms and conditions of employment. (source CFR 29.825.214)

## H. Workers' Compensation

If an employee on workers compensation leave is approved for modified or light duty work but remains qualified for FMLA leave, he or she may still choose not to work and to instead use FMLA leave. However, refusal of the modified or light duty work may lead to loss of workers' compensation benefits.

## **I. Intermittent Leave**

Examples of allowable intermittent FMLA leave include, but are not limited to, transporting a family member to a medical care facility, filling in for primary caregivers, making arrangements for changes in care, periodic medical treatments, or episodic chronic illnesses. (source CFR 29.825.205). Employees on intermittent leave may be temporarily transferred to another similar position, if the transfer helps to accommodate the employee's intermittent leave, until the need for intermittent leave no longer exists.

Intermittent FMLA leave is available for the birth or adoption of a child, but only with employer approval. Employees requesting intermittent leave or reduced hours should schedule their leave so as to disrupt the employer's operations as little as possible. Employees taking intermittent leave should, when possible, submit a schedule disclosing their planned leave. Only the amount of leave actually taken may be counted toward the 12 weeks to which employees are entitled (480 hours for a full time 40 hours a week employee).

## **J. Areas Not Covered in Policy**

This policy is not intended to be all-inclusive. The exceptions and unique situations regarding FMLA benefits are too numerous and complex to address in this policy alone. Consultation with the \_\_\_\_\_ Employee Relations Specialist or legal counsel is strongly advised for situations that involve:

- key employees – salaried employees among the highest paid top 10% of all employees;
- certain educational employees – special requirements and calculations;
- reinstatement issues;
- the need for recertification from a qualified health care provider for a FMLA qualified absence;
- any concurrent ADA or Workers' Compensation situations;
- caring for child who is 18 or older;
- discipline of employees where FMLA leave circumstances may be an issue;
- an employee's request for light duty or intermittent leave; or,
- any other unusual FMLA leave situations.

# **Appendix to Family and Medical Leave Act**

- I. Posting
- II. FMLA Leave Request
- III. Response to FMLA Request - Memorandum of Understanding
  - Medical Documentation – Personal
  - Medical Documentation – Family Member
- IV. FMLA Leave Record



# **Your Rights**

under the

## **Family and Medical Leave Act of 1993**

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to “eligible” employees for certain family and medical reasons.

Employees are eligible if they have worked for a

covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

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### **REASONS FOR TAKING LEAVE:**

Unpaid leave must be granted for any of the following reasons:

- To care for the employee’s child after birth, or placement for adoption or foster care;
- To care for the employee’s spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee’s job.

At the employee or employer’s option, certain kinds of paid leave may be substituted for unpaid leave.

### **ADVANCE NOTICE AND MEDICAL CERTIFICATION:**

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is “foreseeable.”
- An Employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer’s expense) and a fitness for duty report to return to work.

### **JOB BENEFITS AND PROTECTION:**

- For the duration of FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan.”
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

### **UNLAWFUL ACTS BY EMPLOYERS:**

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA.
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

### **ENFORCEMENT:**

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or Local law or collective bargaining agreement which provides greater family or medical leave rights.

### **FOR ADDITIONAL INFORMATION:**

Contact your local Human Resource Office or the:

Division of Human Resources  
700 West State Street  
P.O. Box 83720  
Boise ID 83720-0066

Information provided by the Wage and Hour Division,  
U.S. Government, Department of Labor

## FMLA LEAVE REQUEST FORM

To be completed by employee and/or supervisor, and submitted to the unit human resource contact

Employee \_\_\_\_\_ PCN \_\_\_\_\_ Class Title \_\_\_\_\_

Department/Unit/Section \_\_\_\_\_ Date of Hire \_\_\_\_\_

Supervisor \_\_\_\_\_ Date notified by employee \_\_\_\_\_

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### REASON FOR LEAVE

Adoption of child \_\_\_\_\_ Placement of foster child \_\_\_\_\_ Birth of child \_\_\_\_\_

Serious health condition of employee \_\_\_\_\_

Serious health condition of employees spouse, child or parent \_\_\_\_\_

Provide description/details as appropriate: \_\_\_\_\_

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**TYPE OF LEAVE REQUESTED:** \_\_\_\_Continuous \_\_\_\_Intermittent \_\_\_\_Reduced Hours

If FMLA is approved, do you wish to use available sick leave and/or vacation time while on FMLA? Yes No If so, which do you wish to use? Sick [ ] Vacation [ ]

Explanation of length and type of leave requested: \_\_\_\_\_

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Date leave to start: \_\_\_\_\_ Date of anticipated return to work: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Employee or Representative* *Date*

\_\_\_\_\_  
*Supervisor's Signature*

\_\_\_\_\_  
*Date*

\*\*\*\*\*

Received by: \_\_\_\_\_

\_\_\_\_\_  
*Signature of HR contact*

\_\_\_\_\_  
*Date*

**Family and Medical Leave Act of 1993  
MEMORANDUM OF UNDERSTANDING**

**[Date]**

**TO:**

\_\_\_\_\_  
(Employee's Name)

**FROM:**

\_\_\_\_\_  
(Name of Human Resource Contact, Supervisor or Other Authorized  
Official as appropriate)

**SUBJECT: Family/Medical Leave**

On \_\_\_\_\_ (insert date)

☐ you notified us of your desire to take family/medical leave due to:

☐ we became aware that the leave you are currently taking may qualify as family/medical leave since it is apparently being taken due to:

- ☐ the birth of a child, or the placement of a child for adoption or foster care; or
- ☐ a serious health condition that you need care for; or
- ☐ a serious health condition affecting your: ☐ spouse, ☐ child,
- ☐ parent, for which you are needed to provide care; and you may request that this period of leave be designated as family/medical leave.

We understand that this leave ☐ began or ☐ will need to begin on \_\_\_\_\_ and that you expect to return to work on or about \_\_\_\_\_.

The following information will explain your rights and obligations under the federal Family and Medical Leave Act (FMLA). This explanation makes no attempt to cover all aspects of FMLA that may apply to your situation. Please contact your local Human Resources Office or the FMLA regulations for answers to any questions that you have, now or at any time during FMLA leave.

Except as explained below, you have a right under the FMLA for up to twelve (12) workweeks (480 hours for full-time employees and 360 hours for a 3/4-time employee) of unpaid or paid (or both) leave if:

- a) You were maintained on the payroll as an employee for the State for some part of each of fifty-two (52) weeks; and
- b) You worked at least one thousand two hundred fifty (1,250) hours in the twelve (12) months preceding the effective date of the leave; and
- c) You provided such advance notice as is practical in your particular situation.

### 1. Your Eligibility:

Based on initial review:

You are ☐ eligible ☐ not eligible for leave under the FMLA. (explain).

At this time, you have \_\_\_\_ [insert number] hours of FMLA eligibility.

The twelve (12) months during which FMLA leave may be taken is calculated on a rolling basis, measured backward from the date you use any FMLA leave.

### 2. Leave Designation:

The Department will determine whether the leave you have requested qualifies as FMLA leave. Any period designated as FMLA leave will be counted against your entitlement of twelve (12) weeks of leave. In this case, your requested leave ☐ will ☐ will not be counted against your annual FMLA leave entitlement.

You may choose to use accrued paid sick and vacation leave for your FMLA leave period, whenever use of the leave is allowable under other applicable state and department leave policies and rules. If accrued paid sick or vacation leave is used, those balances will be reduced accordingly. Also, if accrued paid leave is taken, credited state service is accrued. If unpaid leave is taken for FMLA, no credited state service is accrued. Use of accrued compensatory time or earned administrative leave during this period of leave will require management approval, and if used, it will not be counted as part of the twelve (12) weeks you are allowed for FMLA leave.

**Based on the information we currently have available, we estimate that your requested FMLA leave will be calculated as follows [insert numbers]:**

\_\_\_\_\_ **Total hours of FMLA leave consisting of:**

\_\_\_\_\_ **hours of paid sick leave**

\_\_\_\_\_ **hours of paid vacation leave**

\_\_\_\_\_ **hours of unpaid FMLA leave**

### 3. Medical Certification:

You ☐ will ☐ will not be required to furnish a medical certification of the need for leave for a serious health condition. If required, you must return the enclosed certification within fifteen (15) calendar days, unless more time is requested and approved. Be sure the information is complete and signed by the health care provider of your choice. If you fail to return the medical certification, you may be denied the leave.

You ☐ will ☐ will not be required to furnish recertification every 30 days relating to a serious health condition (explain below, if necessary).

### 4. Benefits and Premium Payments:

If you take leave without pay for the FMLA leave period, you must self-pay your portion of the premiums for your medical, dental and supplemental life insurance, if applicable. The Department's share of these premium payments will be made automatically as long as you make the required self-payments. Contact your unit's HR contact for payment requirements and procedures.

If you do not make the required payments, or if you do not make timely payments, your insurance may be canceled. If coverage is canceled during the period of FMLA leave, it will be reinstated immediately upon your return to work. Reinstatement of medical insurance will be made without any qualifying period or physical examination.

For more information, or to determine whether or not you need to self-pay, please refer to your Group Insurance Handbook or call the Office of Group Insurance at 332-1860 or at "www.state.id.us/adm/insurance".

While on FMLA leave, PERSI benefits are "preserved." For example, if you have 57 months of service credit and take three months of unpaid leave for FMLA purposes, when you return to work, you will still have 57 months of service. Under the same scenario, if you take three months of paid leave for FMLA, when you return to work you will have 60 months of service.

#### **5. Return to Work:**

If you do not return to work following FMLA leave for reasons other than the continuation, recurrence, or onset of a serious health condition, or other circumstances beyond your control, you may be required to reimburse the Department for health insurance premiums paid on your behalf during your FMLA leave. Also, if you do not return from FMLA, you should contact the Office of Group Insurance for information regarding your rights for continuance of your life and medical insurance.

While you are on FMLA leave, the terms and conditions of employment pertaining to FMLA leave do not restrict or limit the Department's ability to engage in or impose actions as set forth in the Department's Personnel Policies. Upon your return from FMLA leave, you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment, unless your position has been affected by a layoff, or reorganization during the period of FMLA leave.

The Department may require that you provide a release to return to work if FMLA leave has been taken for your own serious health condition. You ☐ will ☐ will not be required to present a release to return to work prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until such certification is provided.

You ☐ will ☐ will not be required to furnish us with reports of your status and intent to return to work every 30 days while on FMLA leave.

Any of the certification requirements outlined above may change while you are on FMLA leave. If that occurs, we will provide you with written notification of the change with as much advance notice as possible.

I have read and understood the above.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

Attachment: Physician Medical Certification Form (if applicable)

Distribution: 1 copy each to Supervisor, Employee, and Personnel file

## **Family and Medical Leave**

The information sought on this form relates only to the condition for which the employee is taking

\_\_\_\_\_  
Employee Orientation and  
Information Manual

Medical Certification Statement for the **Employee's Own Serious Illness**

1. **Employee's Name:** \_\_\_\_\_
2. **Date condition began:** \_\_\_\_\_
3. **Probable duration of the condition or incapacity:** \_\_\_\_\_
4. **Medical facts regarding the condition (see attached definition of serious illness):**

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5. **Explanation of extent to which employee is unable to perform the functions of his or her job:**

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*I certify that the "serious health condition" described above qualifies as an eligible FMLA condition as described in the attached definition:*

**Health Care Provider Signature:**

\_\_\_\_\_

Date: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Type of Practice (Field of Specialization, if any): \_\_\_\_\_

\_\_\_\_\_

**Medical Release:**

*I authorize the release of any medical information necessary to process the above request. I understand that this medical information will be treated as confidential and will not be placed in my personnel file.*

**Signature of employee or authorized representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Definition of "Serious Health Condition."**

A “Serious Health Condition” means an illness, injury, impairment, or physical or mental condition that involves one of the following:

**1. Hospital Care**

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity<sup>1</sup> or subsequent treatment in connection with or consequent to such inpatient care.

**2. Absence Plus Treatment**

A period of incapacity that also involves treatment<sup>2</sup> by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>3</sup> under the supervision of the health care provider.

**3. Pregnancy**

Any period of incapacity due to pregnancy, or for prenatal care.

**4. Chronic Conditions Requiring Treatments**

A chronic condition which:

- (a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (c) May cause episodic rather than a continuing period of incapacity (e.g., Asthma, diabetes, epilepsy, etc.).

**5. Permanent/Long-term Conditions Requiring Supervision**

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

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<sup>1</sup> “Incapacity,” for purposes of FLMA, is defined to mean inability to perform one or more of the functions of one’s job, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

<sup>2</sup> Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

<sup>3</sup> A regimen of continuing treatment includes, for example, a source of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

## 6. Multiple Treatments (Non-Chronic Conditions)

Any absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity if not treated, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), and kidney disease (dialysis).

## Family and Medical Leave

The information sought on this form relates only to the condition for which the employee is taking FMLA leave.

### Medical Certification Statement for the **Illness of a Family Member**

1. **Employee's Name:** \_\_\_\_\_
2. **Name of ill Family Member:** \_\_\_\_\_
3. **Date condition began:** \_\_\_\_\_
4. **Description and probable duration of the condition or incapacity (see attached definition of serious illness):**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. **Explanation of extent to which employee is needed to care for the ill spouse, child or parent:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I certify that the “**serious health condition**” described above qualifies as an eligible FMLA condition as described in the attached definition:*

### Health Care Provider Signature:

\_\_\_\_\_

Date: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Type of Practice (Field of Specialization, if any): \_\_\_\_\_  
\_\_\_\_\_

### Medical Release:



*I authorize the release of any medical information necessary to process the above request. I understand that this medical information will be treated as confidential and will not be placed in my personnel file.*

**Signature of patient or authorized representative:**

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**Date:** \_\_\_\_\_

**Definition of “Serious Health Condition.”**

A “Serious Health Condition” means an illness, injury, impairment, or physical or mental condition that involves one of the following:

**1. Hospital Care**

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity<sup>7</sup> or subsequent treatment in connection with or consequent to such inpatient care.

**2. Absence Plus Treatment**

A period of incapacity that also involves treatment<sup>8</sup> by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>9</sup> under the supervision of the health care provider.

**3. Pregnancy**

Any period of incapacity due to pregnancy, or for prenatal care.

**4. Chronic Conditions Requiring Treatments**

A chronic condition which:

- (a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

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<sup>7</sup> “Incapacity,” for purposes of FLMA, is defined to mean inability to perform one or more of the functions of one’s job, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

<sup>8</sup> Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

<sup>9</sup> A regimen of continuing treatment includes, for example, a source of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

- (c) May cause episodic rather than a continuing period of incapacity (e.g., Asthma, diabetes, epilepsy, etc.).

## **5. Permanent/Long-term Conditions Requiring Supervision**

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

## **6. Multiple Treatments (Non-Chronic Conditions)**

Any absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity if not treated, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), and kidney disease (dialysis).

## FMLA LEAVE RECORD

For Human Resource Office use only

### ELIGIBILITY FOR LEAVE

Date received: \_\_\_\_\_

Employee Eligibility: \_\_\_ Employee one year \_\_\_ Over 1250 hours worked

Reason for leave qualifies for FMLA leave: Yes \_\_\_ No \_\_\_

If employee deemed not eligible, list reason: \_\_\_\_\_

Amount of present entitlement to FMLA leave: \_\_\_\_\_

Amount of anticipated use for this leave: \_\_\_\_\_

Amount of paid leave available at time of request: \_\_\_\_\_

Vacation \_\_\_\_\_ Sick \_\_\_\_\_ \*Comp Time \_\_\_\_\_ \*EAL \_\_\_\_\_

\*(use of comp and EAL cannot be counted against the FMLA entitlement)

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### NOTIFICATIONS GIVEN:

Did employee receive notice of leave rights? Yes, in employee handbook \_\_\_\_\_

Yes, in specific notice \_\_\_\_\_

Has employee been given notice specifically for this leave request?

Yes \_\_\_ Date given \_\_\_\_\_ No \_\_\_ Date to be given \_\_\_\_\_

**Note: Once notice is given, reflect that on this form.**

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### FURTHER INFORMATION REQUIRED

Is a medical report required? Yes \_\_\_ No \_\_\_

Date employee notified of required report \_\_\_\_\_

Date required report received \_\_\_\_\_ Name of Health Care Provider \_\_\_\_\_

Is clarification from the Health Care Provider necessary? Yes \_\_\_ No \_\_\_

Has employee provided written authorization to contact health care provider? Yes \_\_\_ No \_\_\_

Is a second or third opinion needed? **(Contact your agency HR or Division of Human Resources if considering)** Yes \_\_\_ No \_\_\_

If yes: Date employee notified of requirement \_\_\_\_\_

Date required report received \_\_\_\_\_ Name of Health Care Provider \_\_\_\_\_

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### COMPENSATION AND BENEFITS

Is the leave paid \_\_\_ or unpaid \_\_\_ ?

If paid, how long will it be paid? \_\_\_\_\_

How will employee insurance premiums be paid? \_\_\_\_\_

Has employee been given notice that any paid sick and vacation leave taken during this FMLA qualifying leave will be counted as part of the twelve (12) week FMLA allotment?

Date oral notice given (if applicable) \_\_\_\_\_ Date written notice given \_\_\_\_\_

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### INTERACTION WITH DEPARTMENT POLICY AND OTHER LAWS

Do any other laws apply to this leave? ADA \_\_\_ Workers Comp \_\_\_

Sick Leave \_\_\_ Disability Insurance \_\_\_ Other \_\_\_

If other, indicate specific law or act \_\_\_\_\_

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### REINSTATEMENT RIGHTS

What position will employee return to? \_\_\_\_\_

Will employee be transferred during intermittent leave? \_\_\_\_\_